

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.cbabluevt.com or call 1-888-222-9206. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or call 1-888-222-9206 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall deductible?</p>	<p>\$1,500 individual / \$3,000 family for In-Network providers and \$3,000 individual / \$6,000 family for Out-of-Network providers.</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.</p>
<p>Are there services covered before you meet your deductible?</p>	<p>Yes. In-Network preventive care services are covered before you meet your deductible.</p>	<p>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.</p>
<p>Are there other deductibles for specific services?</p>	<p>Yes. \$50 individual / \$100 family for In-Network prescription drug coverage. There are no other specific deductibles.</p>	<p>You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</p>
<p>What is the out-of-pocket limit for this plan?</p>	<p>\$7,150 individual / \$14,300 family for In-Network providers and \$14,300 individual / \$28,600 family for Out-of-Network providers.</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</p>
<p>What is not included in the out-of-pocket limit?</p>	<p>Premiums, balance-billing charges, pre-certification penalties and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p>
<p>Will you pay less if you use a network provider?</p>	<p>Yes. See www.cbabluevt.com or call 1-888-222-9206 for a list of network providers.</p>	<p>This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Or Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without a referral.</p>



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$60 copay/visit	50% coinsurance after deductible	—————none—————
	Specialist visit	\$75 copay/visit	50% coinsurance after deductible	—————none—————
	Preventive care/screening/immunization	No charge	50% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. See plan document for frequency limitations.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.magellanrx.com	Generic drugs	\$20 copay/prescription (30-day retail); \$60 copay/prescription (90-day retail); \$40 copay/prescription (mail order) after deductible	Not covered	Covers up to a 90-day supply (retail and mail order prescriptions). All prescribed FDA approved contraceptive methods for women are covered at 100% when received from a participating pharmacy. Generic oral contraceptives for women are covered at 100%. The brand version will be covered at 100% when received from a participating pharmacy only if medically necessary or a generic equivalent is not available.
	Preferred brand drugs	\$50 copay/prescription (30-day retail); \$150 copay/prescription (90-day retail); \$100 copay/prescription (mail order) after deductible	Not covered	
	Non-preferred brand drugs	\$80 copay/prescription (30-day retail); \$240 copay/prescription (90-day retail); \$160 copay/prescription (mail order) after deductible	Not covered	
	Specialty drugs	20% coinsurance up to a maximum of \$150 copay/prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you need immediate medical attention	Emergency room care	\$200 copay/visit then 30% coinsurance after in-network deductible		Copayment waived if admitted.
	Emergency medical transportation	30% coinsurance after in-network deductible		_____none_____
	Urgent care	\$75 copay/visit	50% coinsurance after deductible	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300 copay/confinement then 30% coinsurance after deductible	\$300 copay/confinement then 50% coinsurance after deductible	Pre-certification is required.
	Physician/surgeon fees	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$60 copay/visit	50% coinsurance after deductible	_____none_____
	Inpatient services	\$300 copay/confinement then 30% coinsurance after deductible	\$300 copay/confinement then 50% coinsurance after deductible	Pre-certification is required.
If you are pregnant	Office visits	\$60 copay/visit PCP or \$75 copay/visit Specialist applies to first visit to confirm pregnancy, then no charge thereafter for prenatal care 30% coinsurance after deductible for postnatal care	50% coinsurance after deductible	Cost sharing does not apply for preventive services . Depending on the type of service, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% coinsurance after deductible	50% coinsurance after deductible	_____none_____
	Childbirth/delivery facility services	\$300 copay/confinement then 30% coinsurance after deductible	\$300 copay/confinement then 50% coinsurance after deductible	Pre-certification is required for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 25 visits per plan year.
	Rehabilitation services	30% coinsurance after deductible for outpatient \$300 copay/confinement then 30% coinsurance after deductible for inpatient	50% coinsurance after deductible for outpatient \$300 copay/confinement then 50% coinsurance after deductible for inpatient	Outpatient physical, occupational and speech therapy is limited to 30 visits per plan year combined. Pre-certification is required for inpatient services.
	Habilitation services	30% coinsurance after deductible	50% coinsurance after deductible	Outpatient physical, occupational and speech therapy is limited to 30 visits per plan year combined.
	Skilled nursing care	\$300 copay/confinement then 30% coinsurance after deductible	\$300 copay/confinement then 50% coinsurance after deductible	Limited to 100 days per plan year. Pre-certification is required.
	Durable medical equipment	30% coinsurance after deductible	50% coinsurance after deductible	—————none—————
	Hospice services	30% coinsurance after deductible	50% coinsurance after deductible	Limited to 6 months per lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance after deductible	Eye exams are included in the preventive benefit. See plan document for frequency limitations.
	Children's glasses		Not covered	Not covered.
	Children's dental check-up		Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Hearing aids (except due to a birth defect, trauma or illness) Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. Routine foot care Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> Chiropractic care (limited to \$1,000 per plan year) 	<ul style="list-style-type: none"> Private-duty nursing 	<ul style="list-style-type: none"> Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at **1-888-222-9206**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the plan at **1-888-222-9206**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Additionally, a consumer assistance program can help you file your appeal. Contact Vermont Division of Financial Regulation at 89 Main st., Montpelier, VT 05620-3101 or call 800-964-1784. A list of states with Consumer Assistance Programs is available at: <https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers> and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al **1-888-222-9206**

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-888-222-9206**

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码**1-888-222-9206**

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' **1-888-222-9206**

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next section.* —————

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About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$300
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$1,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$300
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$200
Copayments	\$1,800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$1,500
■ Specialist copayment	\$75
■ Hospital (facility) copayment	\$300
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$200
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000